DISEASED TUBES AND OVARIES.

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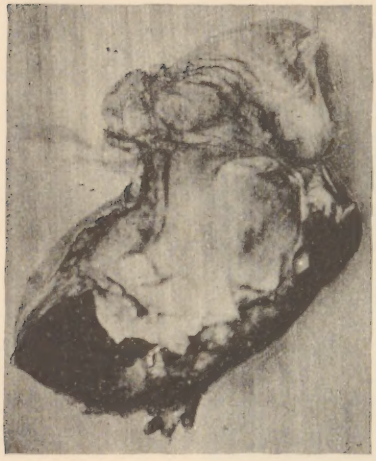

Fig. 1.

Fig. 3.

Fig. 2.

Fig. 4.

EXPLANATION OF PLATES.

Plate I., Fig. 1, Case I., left ovary. Two-thirds natural size. **A,** Rupture of cyst.
Plate I., Figs. 2 and 3, Case II., left ovary and tube. **A,** Clubbed extremity of tube. **B,** Disintegrated ovary. **C,** Omental adhesions. **D,** Remains of pus sac.
Fig. 3. Right ovary and tube. **T,** Clubbed extremity of tube dilated into sac. **O,** Ovary.
Plate I., Fig. 4, Case III. Right ovary. **A,** Ruptured cyst. **B,** Indurated outgrowth.

Fig. 1.

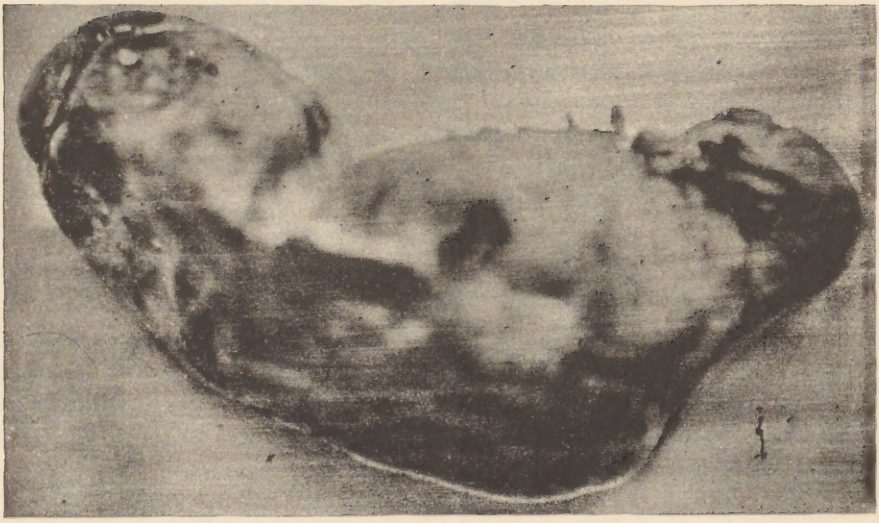

Fig. 2.

Plate II., Fig. 1, Case IV. Left ovary and tube. **T**, Clubbed extremity of tube, dilated into closed sac. **O**, Ovary.

Plate II., Fig. 2, Case V. Cyst of Wolffian body, one-half natural size.

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DISEASED TUBES AND OVARIES.

(PLATES I. AND II.)

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THE most conservative gynæcologist must admit that laparotomy for the removal of diseased Fallopian tubes, and for diseases of the ovaries unaffected by aggressive tumors, has a legitimate place in the surgery of women. The operation has had to contend with a strong spirit of conservatism, but also — and this was the more serious obstacle — with a theory of pelvic pathology that by many was regarded as settled. In fact, in 1857, had the *technique* of abdominal surgery of the present day been brought to equal perfection at that date, we would have been better prepared for it than in 1881. At the former date Bernutz had given us his careful study of the pathology of pelvic, ovarian, and tubal inflammation. It was, however, lost sight of. For twenty years other ideas prevailed. Duncan, Emmet, Churchill, McClintock, and many others — the men who were forming opinion from 1860 to 1880 — familiarized the minds of all with an imaginary pathology. The cellulitis, the parametritis, and the phlegmon were heard of to the exclusion of the tube and ovary. The most radical gynæcologist never expressed more than doubt concerning the real nature of the condition described under these terms. The advanced surgery began to work in advance of the pathology of its time. The true pathology had advanced, and like a wave had receded, for the reason that it had advanced beyond the frontier of the current ideas of the period. What makes a fact such a priceless thing is the difficulty of finding it, — clearing it from the strata of ignorance and error in which it lies buried.

Battey, in America, and Hegar, in Germany (1872), began work on independent lines, and both, as we understand it now, on a misconception

of the pathology of the ovary. It was a true advance, however, and the way was opened. In 1877 Tait practically admitted the inefficiency of the removal of the ovaries in the production of the change of life in bleeding myoma, and showed the necessity of removing the tubes to arrest the hæmorrhage and modify the growth. Attention was thus practically called to the fact of the great change induced in pelvic neoplastic and inflammatory processes by the extirpation of the tubes and ovaries. The opposition came from the pathological school. The observations of Bernutz and Goupil were lost sight of, and the idea that the indurations, adhesions, and inflammatory masses felt in the pelvis were the result of an infiltrate into the cellular spaces, had gained the ascendancy of an established fact. The theory was given greater force by the unfortunate terms, coined by Mathews Duncan, of peri- and para-metritis, designed to explain what were regarded as two well-defined conditions, the causes of one of which resulted in fixation of the uterus, and the other in the mass or phlegmon. That these various pathological states could be the result of an inflammation of tubal origin, and thence invading peritoneal surfaces, and a condition practically incurable without operation, was by some clamorously denied. One reason must not be overlooked, in justice to the pathologists. The laparotomy school had become offensively aggressive. It almost reached the pass that the non-operative gynæcologist had no place left that entitled him to respect. But this active tendency among the extreme surgical school crushed out opposition by what we may term a series of vivisections. By the actual removal of inflamed and disorganized appendages, the adhesions and phlegmons disappeared, and the woman was restored to health, and thus a place for the new surgery was self-created, and pathology was restored back to the period of Bernutz and Goupil. By the year 1884 a multitude of operators were at work in the adventurous field, and to-day there is practically no opposition to laparotomy for the various forms of tubal and ovarian disease of inflammatory origin.

The man who first began to open the abdomen for a purpose other than the removal of an aggressive tumor performed the first act in this surgical evolution. The man who first demonstrated the natural history and morbid structure of pelvic inflammation cleared the way and made a permanent abiding place for the new surgery. Who these men were, we may each have an opinion; but it matters little. History is not the act of one individual, or the date of an event; it is the record of the moral and intellectual evolution that culminates in the man and the event. Not one pair of hands, but many; not one mind alone, but the intellectual evolution of a generation, worked out the problem of tubal inflammation and surgery.

But while the morbid condition of the tubes is freely admitted, the question, What are diseased ovaries? is discussed with but little agreement. To what extent an ovary inflamed, enlarged, contracted, or indurated, will affect the general health, or how necessary its removal, is very far from being settled. My own idea is, that the condition of the ovary has not so much to do with the question as the importance of the organ as a source of influx disturbance would seem to indicate. The condition about the ovary, — the peri-ovarium, — the adhesions, the exudate, appear to be the factors in the local disturbance. It is not the normal ovaries that we are removing now, unless the organs are involved in diseased surroundings. Small cysts scattered over the surface of the ovary, and in some cases encroaching on the parenchyma of the organ, would not warrant extirpation. I have in mind three cases in which the ovaries were in this condition, in which the histories of the patients gave no evidence of ovarian disease. Such an ovary is capable of performing its proper function, and when free from peri-ovaritis, and the tube in a normal condition, it is doubtful if the circle of reflex disturbance would be either widespread or serious. In Case II., in which we find the ovary invaded by a large cyst that appears to have had its origin in the coalescence of a number of smaller cysts, ovarian disease was masked in the symptoms of salpingitis, and a diagnosis to that effect was made. It was embedded in a mass of exudation, the tube was occluded and distended with fluid. It was impossible to get an idea of the condition of the ovary until it was excavated from its bed. In several instances in which I was induced to make what, in my ignorance, I called Battey's operation for the relief of serious menstrual neuroses by causing the change of life, I had cause to give another name to the operations before I was through with them. In every case I found the ovaries firmly bound down by adhesions, without any antecedent history of so-called pelvic cellulitis. In such a case I believe the symptoms were due to the peri-ovaritis, and not to the condition of the ovary itself.

Many able physicians make the practical objections to laparotomy for diseased tubes, that patients may make perfect recoveries from serious attacks of pelvic inflammation; that phlegmons disappear without suppuration, and that adhesions melt away. Cases of this kind are within the experience of every one. Here the question comes up, How are we to distinguish between a case that will reach a spontaneous cure and one that will never recover without extirpation of the diseased ovaries and tubes? There must be a pathological difference either in degree or kind. I say there must be, because I have never seen an instance of pyosalpinx that got well spontaneously. We hear occasionally that galvanism, or mas-

sage, or puncture cured cases of this nature; but we always have the suspicion that there was a mistake somewhere. I have an explanation of this seeming pathological contradiction, that to me, in my present knowledge, is a reasonable one. I would reapply the terms of Mathew Duncan, not as explaining cellulitis and the board-like induration of this author, but as applied to all the pelvic genitalia, and not confined to the uterus. I would have peri- and para-salpingitis and like terms applied to the ovaries. As an example of this take the condition in Case I. as an illustration; here the tube and the ovary were enclosed in a mass of exudate, so that when the fingers were introduced a smooth, uniform mass was felt, but neither tube nor ovary. It was possible to enucleate them by tracing the mass outward from the uterus. Conceive of such a state of affairs existing without the element of salpingitis or without disease of the ovary other than its adhesions. Such a condition might typify a form of pelvic inflammation that would tend to spontaneous cure. Associated with a distended and occluded tube we have another state that could not conform to the law of resolution or absorption, but would persist, for months or years, a depot of inflammatory material, always ready for renewed activity. The form then of pelvic inflammation in which spontaneous cure takes place is that of peri-salpingitis and peri-ovaritis, and in which the tube and ovary are left comparatively uninjured. In such a condition we would have masses of considerable dimensions terminate without suppuration in resolution and absorption, a termination that is familiar to us all. It is, to my mind, easier to explain this spontaneous cure as a different thing from the relapsing or incurable form, than as different degrees of the same thing.

The only difficulty in the way of this explanation is the theory that the route of the inflammatory invasion is always through the tube; but I cannot see why we may not assume that the tube could act as the conductor of the infecting agent with comparative safety, while the pelvic peritonæum, less able to withstand the infection, would at once become involved in adhesive inflammation and exudate. My explanation also allows for difference in the infecting agent. Some causes, like the gonorrhœal poison, for instance, expend their force upon the mucous membranes, in which case tubes and peritonæum would suffer alike. Other forms of bacterial infection pass over mucous surfaces without damage, but attack the peritonæum with avidity. One form would subject the woman to hopeless invalidism or salpingotomy; the other would tend naturally to cure. In this way we are able to explain contradictory clinical facts with the very practical bearing, that knowing the nature of the infecting agent, as we sometimes do, in one case we can temporize, and in the other resort to laparotomy.

The following report of cases will serve to illustrate some of the points already noticed: —

Case I. — Married; unipara; aged 31. A patient of Dr. Lamb, of Georgetown, N.Y. She had been for six years crippled by left-sided pelvic pain and tenderness on very slight exertion. At irregular intervals for a long time had attacks of muscular spasms, which had been regarded as epileptic, but which were hysteroid. Menstruation profuse, moderately painful. Nutrition unimpaired. Received treatment of some kind at the Woman's Hospital in New York. Admitted to the Syracuse Women's and Children's Hospital. Examination revealed a mass limited to the left broad ligament, immobile, sensitive, with no fluctuation apparent. Movement of uterus partially restricted. Cervix lacerated bilaterally. A diagnosis of salpingitis was made.

Operation. — The left Fallopian tube convoluted, distended, thickened. Left ovary degenerated into a thick walled cyst, one and a half inches in diameter, all deeply embedded in a mass of organized exudation. Enucleation difficult. Uneventful recovery. (Plate I., Fig. 1.)

May 21, 1889. Her physician reports a continuance of hysteria. Local symptoms improved.

Case II. — Mrs. B., aged 28 years; sterile. Patient of Dr. Magee, of Syracuse. For five years prior to seeing patient, she had presented symptoms such as usually attend pelvic cellulitis, attended with intervals of relapse, during which she was confined to her bed with pain and moderate fever, followed by escape of pus from the vagina. The pus was supposed to escape through a fistulous opening into the vagina. Careful examination failed to discover such an opening. Thickening and induration was proved to exist in the direction of both tubes. Moderate uterine fixation. Careful search, at favorable moments, proved that the pus escaped from the os externum. Diagnosis of pyosalpinx. Laparotomy was suggested to the patient, and eagerly accepted. Admitted to the Women's and Children's Hospital, and operation done. (Plate I., Figs. 2 and 3.)

Aside from suppuration in the abdominal wound, recovery was without event. Both tubes and ovaries removed. June 1, 1889, Mrs. B. called upon me, walking over a mile. Has gained greatly in flesh and perfectly restored to health. She menstruated after the operation, and has continued so to do every month since.

Case III. — Miss W.; single; age, 25 years; a patient of Dr. Magee, of Syracuse. A delicate, anæmic girl. Able to do no work or take exercise, from the presence of a severe wearing pain, with tenderness in the right ovarian region. Examination revealed the uterus anteverted, of normal dimensions, with moderate cervical catarrh. Bimanual palpation

gave great tenderness in the right iliac fossa. From the chronic nature of the ailment, and its sudden onset in an acute attack of pelvic pain and tenderness, the diagnosis of salpingitis was made and laparotomy advised.

Admitted to the Central New York Hospital for Women, and laparotomy made Dec. 6, 1889. The right ovary was found hypertrophied, hardened; tube tortuous, occluded, its fimbriæ obliterated. The ovary and tube removed. Left ovary found normal and not disturbed. Recovery rapid and cure complete. (Plate II., Fig. 1.)

Case IV. — Mrs. B., of Central square, N.Y., aged 29; married; sterile. Menstruation irregular at intervals of three, six, or, in one instance, of twelve months. Nutrition impaired. Suffered for three years from cephalalgia, aggravated to intensity on the rare occasions of menstruation; sacralgia; right and left ovarialgia. Locally the uterus was movable; slightly retroverted; slightly undersized; some slight enlargement in direction; both tubes, no tenderness on thorough palpation. A diagnosis of ovarian neurosis was made, and after a conversance of several months no suspicion of salpingitis was entertained. The operation of ovarian extirpation was never suggested to her; but the patient got the idea from some one, and requested that it be made in order to induce the change of life. As she was hopelessly sterile, and suffering constant misery, the operation appeared highly proper; to that end she was admitted to the Central New York Hospital for Women, and laparotomy made Jan. 9, 1889. Both tubes were occluded, fimbriæ obliterated, and club-shaped; left ovary softened, friable, adherent to surrounding parts, and right ovary beset with a number of small cysts. Recovery speedy and without event.

May 20, 1889. Patient has gained the appearance of much better health. The headaches have nearly disappeared. Has had three attacks since the operation, but was not obliged to take morphia. (Plate II., Fig. 2.)

Case V. — Mrs. I., aged 49; married; four children; a patient of Dr. Pardu, of Fulton, N.Y. Abdomen enormously distended by what appeared to be encysted ascites. Pelvic examination revealed a considerable mass to the left of the uterus, slightly movable and unattached to that organ. No diagnosis was made, but laparotomy advised. As respiration and locomotion were difficult, from abdominal distention, she readily consented. Admitted to the Central New York Hospital for Women, and laparotomy made Jan. 14, 1889. Peritonæum thickened, large patches of olive-green discoloration over parietes. Transverse colon and intestines adherent. Cavity contained about forty pounds of amber-colored fluid; upon the left, attached by a thin tubal mesentery, was a cyst six inches long, by three in diameter, darkly purple, and very vascular. The thin

attachment ligated and cyst removed. Ovary and tube healthy and not removed. Right tube and ovary normal. An exceeding rapid recovery. When first admitted to the hospital her temperature was subnormal. This was attributed to fright, as several operations were being made daily in the house, and the patient's dread was excessive, and without any special treatment the temperature became normal. This was probably a cyst of the Wolffian body. Its nearly exact counterpart is described by Mr. Tait, "Diseases of Women," Lond., 1877, p. 221. The case is included in this series for its diagnostic value, as previous to laparotomy it resembled nothing so much as a distended tube with diffused exudative peritonitis. (Plate II., Fig. 3.)

Case VI. — Mrs. W., aged 32; married; sterile. Excessive dismenorrhœa; wide-spread neurosis; mental irritability; insomnia; morphia habit induced by excessive pain. Patient applied to have ovaries extirpated. As her case had long been familiar, her request was acceded to. Declined to enter the hospital. Attended her at her own home in Wolcott, N.Y., assisted by Dr. A. B. Breese, of Syracuse. Both ovaries were beset of a large number of small cysts; the fimbriæ were adherent to the ovaries. Both ovaries and tubes removed. Recovery somewhat delayed by abscess in abdominal wound. Menstruation ceased. But little is known of the subsequent history of the patient, as her physician has made no reply to repeated requests for information.

Case VII. — Mrs. B., of Marcellus, N.Y., patient of Dr. C. Billington; aged 34; sterile. Spare and much reduced by excessive pain, located in a mass in right pelvic space, evident on both external and internal palpation. Tumor indurated and very tender. Uterus mobile and anteverted by tumor, which was slightly posterior. Admitted to Central New York Hospital for Women, and laparotomy made in presence of Drs. A. B. Randall, C. Hall, and Billington. Right ovary enormously hypertrophied, bound down posteriorly by a meso-ovarium, indurated; tube occluded; fimbriæ obliterated; ovary removed. Recovery very rapid, with subsequently perfect health.